

**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_ SEX:  M  F If female, are you pregnant?  Y  N  
 Age: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Primary Language Spoken: \_\_\_\_\_ Other: \_\_\_\_\_  
 Referring Doctor/PCP: \_\_\_\_\_ Home #: \_\_\_\_\_ Cellular #: \_\_\_\_\_  
**Chief Complaint:** \_\_\_\_\_  
**Reason for Visit:** \_\_\_\_\_

**Past Medical History/Health Conditions (Circle any Positives):**

HEAD-SINUSES: FACIAL PAIN / HEADACHES / CONGESTION / HEAD OR FACIAL TRAUMA / SINUSITIS HISTORY OF SINUS SURGERY	NONE <input type="checkbox"/>
EARS-HEARING: PAIN / HEARING LOSS / RINGING IN THE EARS / PRESSURE / LOSS OF BALANCE / ITCHING / DRAINING / INFECTIONS / MASTOIDITIS / EAR WAX	NONE <input type="checkbox"/>
NOSE: CONGESTION / BLEEDING / SNEEZING / RUNNY NOSE / LOSS OF SMELL / PRESSURE / ITCHING / POST NASAL DRAINAGE	NONE <input type="checkbox"/>
MOUTH: DENTAL PROBLEM / DRY MOUTH / BAD BREATH / COLD SORES / ULCERATIONS / PAROTITIS / BLEEDING	NONE <input type="checkbox"/>
THROAT: SORE / HOARSENESS / LOSS OF TASTE / BAD TASTE / WHITE SPOTS / LESIONS / SNORING / TONSILLITIS	NONE <input type="checkbox"/>
RESPIRATORY: SHORTNESS OF BREATH / COUGH / WHEEZING / COUGHING UP BLOOD / <u>ASTHMA</u> / PNEUMONIA / BRONCHITIS	NONE <input type="checkbox"/>
GI: DIFFICULTY SWALLOWING / HEARTBURN / <u>REFLUX</u> / DIARRHEA / NAUSEA / VOMITING / GASTRITIS / HIATAL HERNIA	NONE <input type="checkbox"/>
NEUROLOGICAL: HEADACHES / PASSING OUT / DIZZINESS / NUMBNESS / <u>STROKE</u> / SEIZURES / TREMORS	NONE <input type="checkbox"/>
CARDIOVASCULAR: <u>HYPERTENSION</u> / <u>MVP</u> / HIGH CHOLESTEROL / <u>PAST HEART ATTACKS</u>	NONE <input type="checkbox"/>
GU: PROSTATE / KIDNEY STONE / DIALYSIS / CONGENITAL PROBLEMS / GOUT / INFECTIONS	NONE <input type="checkbox"/>
CONSTITUTIONAL SYMPTOMS: FATIGUE / FEVER / CHILLS / NIGHT SWEATS / WEIGHT LOSS OR GAIN / FAINTING	NONE <input type="checkbox"/>
EYES: DOUBLE VISION / ITCHING / VISION LOSS / PAIN / BURNING / TEARING / DRY EYES / GLASSES / <u>GLAUCOMA</u>	NONE <input type="checkbox"/>
SKIN: RASH / ITCHING / LESIONS / HIVES / HISTORY OF SKIN CANCER	NONE <input type="checkbox"/>
MUSCULOSKELETAL: JOINT PAIN / ARTHRITIS / JAW PAIN / MUSCULAR DYSTROPHY / FRACTURES / GOUT / OSTEOPOROSIS / LUPUS	NONE <input type="checkbox"/>
PSYCHIATRIC: ANXIETY / SLEEP DISORDER- SNORING OR APNEA / MEMORY LOSS / DRUG ADDICTION / DEPRESSION	NONE <input type="checkbox"/>
ENDOCRINE: <u>DIABETES</u> / OBESITY / HAIR LOSS / <u>THYROID DISEASE</u> / PARATHYROID DISEASE / PITUITARY DISEASE / LUPUS	NONE <input type="checkbox"/>
HEMATOLOGIC-LYMPHATIC: NECK MASSES / BRUISING / BLEEDING / ANEMIA / IMMUNE PROBLEMS / PVT PULMONARY EMBOLISM	NONE <input type="checkbox"/>
ANY OTHER MEDICAL CONDITIONS:	

**Past Surgical History:**  Y  N If yes, please list the procedures and dates: \_\_\_\_\_

**Family History of Medical Problems:**  Y  N If yes, please list and indicate family member: \_\_\_\_\_

Are you currently using **tobacco** products?  Y  N If yes, quantity smoked per day: \_\_\_\_\_

If you quit, how often did you smoke before (per day)? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink **alcohol**?  Y  N If yes, amount: \_\_\_\_\_ How often: \_\_\_\_\_

Do you currently have or have you in the past had a problem with **substance abuse**?  Y  N

Please list all **allergies** below (including medication, environmental, and/or food allergies):  No Allergies

List all **medications** you are currently taking (including all over the counter medications and vitamins):  None

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(If patient is a minor, please indicate the person completing the Medical History and the relationship to patient)*